VERMONT

"GENERAL" SPECIALTY - Prior Authorization and Patient Enrollment Form

USE WHEN NO DRUG SPECIFIC FORM EXISTS - Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Sex	Medicaid ID #
	M ☐ F ☐	

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone

Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office of Vermont Health Access
"GENERAL" SPECIALTY MEDICATIONS (Not drug specific)
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

Drug Requested:_____

Strength, Route & Frequency:_____

Length of therapy:_____

Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this particular medication:

_____

Was patient seen by any other provider for this condition? ☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

Medications previously tried and failed for this condition:

Name of medication	Type of failure	Date

Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure/Test	Findings	Date

Other Information/ comments:

_____

_____

4 PRESCRIPTION

Drug Name/Strength:_____

Sig: Dose: _____ Route: _____ Frequency: _____

Qty: _____ Refill X:_____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 10/2008